

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3172

## CERTIFICATE OF DEATH

03155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>217 Hollingsworth Manor</u>	
3. NAME OF DECEASED (Type or print) First <u>Dallas</u> Middle <u>M.</u> Last <u>ADAMS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1911</u>
9. AGE (In years last birthday) <u>46 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion Dalton</u>		14. MOTHER'S MAIDEN NAME <u>Delia Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James W. Adams</u>		Address <u>Elkton, Md.</u> <u>217 Hollingsworth Manor,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> <u>541.1</u> DUE TO (b) <u>PERITONITIS</u> DUE TO (c) <u>PERFORATED</u> DUE TO (c) <u>RUPTURED GASTRIC ULCER</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>10 DAYS</u> <u>10 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 27</u> , 19 <u>58</u> , to <u>MARCH 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 8</u> , 19 <u>58</u> , and that death occurred at <u>2:20 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS</u>		<u>CHESAPEAKE CITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 13 '58</u>	
ADDRESS <u>Elkton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

RECEIVED

3173

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 136 Maffitt Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alice Boyd		4. DATE OF DEATH Month March Day 26 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1885
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Charles Boyd		14. MOTHER'S MAIDEN NAME Joanna T. Connors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-1394	
17. INFORMANT Mrs. Rose Stevens, Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 15, 19 58, to March 26, 19 58, that I last saw the deceased alive on March 26, 19 58, and that death occurred at 3:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main Street	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		DATE SIGNED 3/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Harrisburg, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		Male		45		Jan 1, 1905		Baltimore		Baltimore		Baltimore		Maryland	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
Carpenter		Heart Disease		Natural		Mar 31, 1958		Baltimore		Baltimore		Baltimore		Maryland	
Physician		Date of Death		Time of Death		Place of Death		City		County		State		Signature of Physician	
J. H. Harris		Mar 31, 1958		10:00 AM		Baltimore		Baltimore		Baltimore		Maryland		J. H. Harris	
Funeral Home		Burial Place		Date of Burial		Place of Burial		City		County		State		Signature of Funeral Home	
Harris & Sons		Baltimore		Mar 31, 1958		Baltimore		Baltimore		Baltimore		Maryland		Harris & Sons	

BUREAU V. E.

MAR 31 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3190

## CERTIFICATE OF DEATH

## 03157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, RD</b>				c. LENGTH OF STAY IN 1b <b>42 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>O.</b> Last <b>BURTON</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/83</b>	9. AGE (In years lost birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Burton</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Effie P. Burton, Perryville, RD, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cerebrovascular Accident</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 55</b> to <b>March 24 19 58</b> , that I last saw the deceased alive on <b>March 23 19 58</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. H. Richards, Jr., M.D.</b>		ADDRESS (Street, city or town, state) <b>18 - 40 - 100 - X, 2nd 33x58</b>					
PHYSICIAN'S NAME (Type) <b>G. H. Richards, Jr., M.D.</b>		DATE SIGNED <b>3/24/58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Principio Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Principio Furnace, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Debra Patterson</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 27 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>							

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 27 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3174

## CERTIFICATE OF DEATH

Reg. Dist. No. 03158

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>One day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>George</b> Last <b>Carter</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1902</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Rowlandsville, Md.</b>	
11. CITIZEN OF WHAT COUNTRY? <b>US.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US.</b>	
13. FATHER'S NAME <b>Edward Carter</b>		14. MOTHER'S MAIDEN NAME <b>Anna J. Boddy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>22-2-10-8457</b>	
17. INFORMANT <b>Mrs. Helen Alexander Rising Sun Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Nose extending to the sinus</b> <b>160.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>causing Hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-25</b> , 19 <b>58</b> , to <b>3-7-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-7-58</b> , 19 <b>58</b> , and that death occurred at <b>8 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>3-8-58</b>			
ACTUAL SIGNATURE <b>R. C. Dodson</b> M.D.		DATE SIGNED <b>3-8-58</b>	
PHYSICIAN'S NAME (Type) <b>R. C. Dodson M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 11, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>mt. Zoar</b>		22d. LOCATION (City, town, or county) (State) <b>Near Conowingo, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 11 '58</b>	
ADDRESS <b>Rising Sun, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. S.

MAR 11 1928

RECEIVED

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HODGSON		45		M		W		1883		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1905		BALTIMORE, MD.		JANE H. HODGSON		1927		BALTIMORE, MD.	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CLOCK REPAIRER		1920		BALTIMORE, MD.		HODGSON & SONS		1927		BALTIMORE, MD.	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1927		BALTIMORE, MD.		J. H. HODGSON		1927		BALTIMORE, MD.	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		NAME OF CORoner		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1927		BALTIMORE, MD.		J. H. HODGSON		1927		BALTIMORE, MD.	
SIGNATURE OF DECEASED		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HODGSON		1927		BALTIMORE, MD.		J. H. HODGSON		1927		BALTIMORE, MD.	

Statement of the cause extending to the cause causing the death

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HODGSON		45		M		W		1883		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1905		BALTIMORE, MD.		JANE H. HODGSON		1927		BALTIMORE, MD.	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CLOCK REPAIRER		1920		BALTIMORE, MD.		HODGSON & SONS		1927		BALTIMORE, MD.	
CAUSE OF DEATH		DATE OF CAUSE OF DEATH		PLACE OF CAUSE OF DEATH		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1927		BALTIMORE, MD.		J. H. HODGSON		1927		BALTIMORE, MD.	
MANNER OF DEATH		DATE OF MANNER OF DEATH		PLACE OF MANNER OF DEATH		NAME OF CORoner		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1927		BALTIMORE, MD.		J. H. HODGSON		1927		BALTIMORE, MD.	
SIGNATURE OF DECEASED		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HODGSON		1927		BALTIMORE, MD.		J. H. HODGSON		1927		BALTIMORE, MD.	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3191

## CERTIFICATE OF DEATH

03159

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN b <b>3 mos 12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Northeast</b> <input checked="" type="checkbox"/> d. STREET ADDRESS <b>Unknown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLETCHER F. CARTER</b>		4. DATE OF DEATH Month Day Year <b>March 15 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-90</b>
9. AGE (In years lost birthday) yrs. <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Shelby, Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mack S. Carter</b>		14. MOTHER'S MAIDEN NAME <b>Nannie Deramus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, cerebral, right sided.</b> 180x DUE TO <b>Generalized Metastases - ("Brain, Lung, Liver, Kidney, Bones and Supra-Renals.)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Hypernephroma, right kidney.</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 Hours</b> <b>Over 6 months.</b> <b>Over 1 year.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-3</b> , 19 <b>57</b> , to <b>3-15</b> , 19 <b>58</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, Perry Point, Md. 3-16-58</b> ACTUAL SIGNATURE <b>E. S. Ellis, M.D.</b> PHYSICIAN'S NAME (Type) <b>E. S. ELIS, M.D., Acting Director, Professional Services.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Principio Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Principio Furnace, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b> ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>			

MAR 18 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3192

## CERTIFICATE OF DEATH

03160

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10yrs.3mo.11days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK H. CHESLEY		4. DATE OF DEATH Month Day Year March 11 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-18
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Hilton Chesley - Deceased	
14. MOTHER'S MAIDEN NAME Wade Butler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Uremia, uremic poisoning (clinical) DUE TO (b) Hypertensive cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5-6 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-28, 19 47, to March 11, 19 58, and that death occurred at 4:40 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. LACERVA		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 3-12-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/14/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '58	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 18 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03161

Reg. Dist. No.

3175

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Devine Nursing Home				d. STREET ADDRESS 7			
3. NAME OF DECEASED (Type or print) First Middle Last Oleita - Collins				4. DATE OF DEATH Month Day Year 3 - 19 19 58			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME no information				14. MOTHER'S MAIDEN NAME no information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Dr. C.B. Collins Devine Nursing Home Elkton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Chronic myocarditis DUE TO (b) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. R.C. Dodson				DATE SIGNED 3-19-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-1958		22c. NAME OF CEMETERY OR CREMATORY North East, Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Md		24a. REGISTRY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature of the medical examiner.

RECEIVED  
MAR 24 1958  
BUREAU V. S.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03162

3176

1. PLACE OF DEATH a. COUNTY <u>Dee!</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dee!</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Cornuelle</u>				4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/3/1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Wm Cornuelle</u>				14. MOTHER'S MAIDEN NAME <u>Laura E. Sutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-1596</u>		17. INFORMANT <u>Clark J. Cornuelle, Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis with myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x diabetes, mild</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 21</u> , <u>1958</u> , to <u>March 24</u> , <u>1958</u> , that I last saw the deceased alive on <u>March 24</u> , <u>1958</u> , and that death occurred at <u>8:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>				ADDRESS (Street, city or town, state) <u>233 E. Main Street</u>			
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>				DATE SIGNED <u>March 24, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barriag</u>				ADDRESS <u>Aberdeen Maryland</u>		24. REC'D BY REGISTRAR <u>W. B. Smith</u>	
				DATE <u>MAR 31 '58</u>			

# CERTIFICATE OF DEATH

MD-201-10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1910</i>		6. PLACE OF BIRTH <i>St. Louis, Mo.</i>		7. DATE OF DEATH <i>Mar 10 1955</i>		8. PLACE OF DEATH <i>St. Louis, Mo.</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>		11. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

MAR 31 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3193

## CERTIFICATE OF DEATH

03163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notttingham Rural</u>				c. LENGTH OF STAY IN TB <u>1 yr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Graybeals Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Andrew</u> Last <u>Dollenger</u>				4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1858</u>	9. AGE (In years last birthday) <u>99</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill-Rest Busi.</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John A. Dollenger</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Pieper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Adolph Dollenger</u>				Address <u>16 Harmonistue Rising Sun Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardine decompensation</u> DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	Month <u>  </u> Day <u>  </u> Year <u>1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>March 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>58</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>			
DATE SIGNED <u>3/24/58</u>				DATE SIGNED <u>3/26/58</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor</u>				ADDRESS <u>Rising Sun, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig</u>				ADDRESS <u>2024 Orleans St.</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>  </u>
DATE <u>MAR 31 '58</u>				DATE <u>  </u>			

CERTIFICATE OF DEATH

1938

Form with multiple sections for death certificate, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 31 1938

RECEIVED

3194

## CERTIFICATE OF DEATH

03164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>CECIL</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>CECIL</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CECILTON</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <i>SAMUEL</i> First <i>EVERETT</i> Middle <i>LAST</i> Last				4. DATE OF DEATH <i>MARCH</i> Month <i>10</i> Day <i>1958</i> Year			
5. SEX <i>M.</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JULY 31, 1881</i>	
9. AGE (In years last birthday) <i>76</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>SAMUEL EVERETT</i>				14. MOTHER'S MAIDEN NAME <i>SARAH J. SHELTON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. W<sup>m</sup>. HAGUE,</i> Address <i>CECILTON, MD.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>2 previous cerebro-vascular accidents</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>11 mar</i> , 19 <i>57</i> , to <i>10 mar</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10 mar</i> , 19 <i>58</i> , and that death occurred at <i>5:50</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>12 Mar 58</i>							
ACTUAL SIGNATURE <i>Wallace Oberheim</i> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/13/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MASSEY CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>MASSEY MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Hellows, Hillington, Md.</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>MAR 14 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Overbach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. 8

14 MAR 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03165

3195 Item 2 Film G227 3-31-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> <b>Indiana</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bainbridge Fort Wayne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 1 and 222</b>		e. STREET ADDRESS <b>2817 New Haven Avenue</b> <b>Bainbridge Naval T. Sta.</b>	
3. NAME OF DECEASED (Type or print) First <b>Marilyn Louise</b> Middle <b>Fenker</b> Last <b>Fenker</b>		4. DATE OF DEATH Month <b>3</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1934</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank L. Fenker</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>316 32 4275</b>	
17. INFORMANT <b>Navy Records, NTC, Bainbridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Base of skull and neck</b> <b>823X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>823X</b> (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car went down an embankment 90 feet</b>	
20c. TIME OF INJURY Month, Day, Year <b>11.15 3 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 1 and 222 Conowingo Cecil Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Fort Wayne, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		March 25, 1958	
Place of Death		Cause of Death		Manner of Death		Occupation	
Home		Heart Disease		Natural		Teacher	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

**RECEIVED**  
MAR 26 1958  
BUREAU X 2

Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	

3196

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 17yrs.7mo.13days		d. STREET ADDRESS 1612 D Street, S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> unknown	
3. NAME OF DECEASED (Type or print) First Middle Last CORENTH (NMI) FITTS		4. DATE OF DEATH Month Day Year March 20 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-97
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Office Building	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Fitts		14. MOTHER'S MAIDEN NAME Clara (maiden name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491 x Arteriosclerosis generalized - unknown			INTERVAL BETWEEN ONSET AND DEATH 5-6 days unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1940, to March 20, 19 58, and that death occurred at 4:20a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 3-21-58			
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-25-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE MAR 31 1958		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.  
CERTIFICATE OF DEATH

BUREAU V. 2

MAR 31 1938

RECEIVED

03167

3177

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md.		b. COUNTY		Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Elkton				Life		X Chesapeake City									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						1d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Union															
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Robert		B.		Foard				March 19,				19		58	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
Male		White				July 31, 1874		83 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Store-keeper				General		Maryland				U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME									
Eli J. Foard						Mary E. Billney									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		None		Mrs. Adelaide W. Foard		Chesapeake City Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC MYOCARDITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH ONE WEEK 5 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from March 16, 1958, to March 19, 1958, that I last saw the deceased alive on March 19, 1958, and that death occurred at 11:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. CHESAPEAKE CITY MD 3/20/58 PHYSICIAN'S NAME (Type) Henry Davis M.D. Chesapeake City, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)							
Burial		Mar. 23, 1958		Bethel Cemetery				Nr. Chesapeake City, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Pippin Funeral Home						1212 E. Elkton, Md.		DATE MAR 26 '58		[Signature]					



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF BIRTH [Illegible]		5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. COLOR [Illegible]		9. RELIGION [Illegible]	
10. DATE OF DEATH [Illegible]		11. PLACE OF DEATH [Illegible]		12. CAUSE OF DEATH [Illegible]	
13. MEDICAL HISTORY [Illegible]		14. HISTORY OF PRESENT ILLNESS [Illegible]		15. POST-MORTEM EXAMINATION [Illegible]	
16. SIGNATURE OF PHYSICIAN [Illegible]		17. SIGNATURE OF CORONER [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF WITNESS [Illegible]	

BURKAV Y. B.

MAR 26 1958

RECEIVED



# MDARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## Replacement Cert. 4-15-58 am MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03168

Reg. Dist. No.

3197

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, R.D.</b>		c. LENGTH OF STAY IN 1b <b>All life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun R.D.</b>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Jimison</b> Last <b>Fox</b>		d. STREET ADDRESS <b>1</b>	
4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>1958</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-5-1906</b>
9. AGE (in years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months <b>51</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Rising Sun, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter S. Fox</b>		14. MOTHER'S MAIDEN NAME <b>Elva McCullough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-74-6888</b>	
17. INFORMANT <b>Mrs. Virginia Fox, Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Back and Chest.</b> 910.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Porch roof collapsed and fell on him.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>3</b> p. m. <b>20, 58</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Rising Sun R.D. Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosebank</b>		22d. LOCATION (City, town, or county) (State) <b>Calvert Cecil Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph M. Reed, Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Mar 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>A.W. Hedrich</b>		DATE SIGNED <b>3-22-58</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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\* Turned back and lost it.

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Figure 5

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03169

Item 14, Film G-227 4/10/58. cac

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Cecil</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Cecil</span>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Elkton</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">30yrs</span>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Elkton</span>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Union Hospital. D.O.A.</span>						d. STREET ADDRESS <span style="font-size: 1.2em;">123 Singerly Ave.</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">William</span> Middle <span style="font-size: 1.2em;">H</span> Last <span style="font-size: 1.2em;">Fox, Sr.</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">3</span> Day <span style="font-size: 1.2em;">6</span> Year <span style="font-size: 1.2em;">19 58</span>											
5. SEX <span style="font-size: 1.2em;">M</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">W</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">11-15-1897</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">60</span> yrs.		IF UNDER 1 YEAR Months      Days      Hours      Min.		IF UNDER 24 HRS. Hours      Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Contractor &amp; Builder</span>				10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">All building</span>				11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Pennsylvania</span>				12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">Bernard Fox</span>						14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary/McCreary Angeline Houck</span>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>				16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">218-32-0763</span>				17. INFORMANT <span style="font-size: 1.2em;">Mrs. Wm. H. Fox.</span>				Address <span style="font-size: 1.2em;">123 Singerly Ave</span>		Elkton, Md.	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Pulmonary Hemorrhage</span>            DUE TO            Conditions, if any, which gave rise to immediate cause (b) <span style="font-size: 1.2em;">Extreme Arteriosclerosis</span>            (c), stating the underlying cause last. <span style="font-size: 1.2em;">450.0</span> </div> <div style="width: 35%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH         </div> </div>															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour      a. m.      p. m.      Month, Day, Year <span style="font-size: 1.2em;">19</span>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <span style="font-size: 1.5em; font-family: cursive;">R. C. Dodson</span>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">R. C. Dodson</span>						DATE SIGNED <span style="font-size: 1.2em;">3-9-58</span>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>				22b. DATE THEREOF <span style="font-size: 1.2em;">3/10/58</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Elverson Meth. Cemetery Elverson</span>				22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Penna.</span>					
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em; font-family: cursive;">Ralph E. Hicks</span>						ADDRESS <span style="font-size: 1.2em;">Elkton, Md.</span>				24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">MAR 13 58</span>		24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em; font-family: cursive;">[Signature]</span>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

ALLIANCE STATE DEPARTMENT OF HEALTH - BATHINGORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAR 13 1958  
BURKAY Y. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

3179

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 W. Main St.				d. STREET ADDRESS 225 W. Main St.			
3. NAME OF DECEASED (Type or print) First Middle Last Ralph Edward Garrett				4. DATE OF DEATH Month 3 Day 30 Year 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1889		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cival Eng		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry D. Garrett				14. MOTHER'S MAIDEN NAME Lucy J. Spittle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.1 219-05-5675		17. INFORMANT Mrs. Hester Garrett, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-31-58	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/58		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.				24a. REC'D BY REGISTRAR APR 2 '58		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



APR 2 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03171

3198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Annie Nancy Goodnow		4. DATE OF DEATH Month Day Year March 1 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jones		14. MOTHER'S MAIDEN NAME Margaret Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Delbert R. Goodnow		Address North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Renal Disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Calculus Cholecystitis</u>			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/27, 1956, to 1 March, 1958, that I last saw the deceased alive on 1 March, 1958, and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. North East, Md. 3 March '58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-5-58	22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	22d. LOCATION (City, town, or county) (State) North East, Cecil Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Grant		24a. REC'D BY REGISTRAR DATE MAR 6 '58	
ADDRESS North East, Maryland.		24b. REGISTRAR'S SIGNATURE O. L. Lane	

CERTIFICATE OF DEATH

Form 100, Rev. 1-25

NAME OF DECEASED MATTIAS		DATE OF BIRTH	
SEX		AGE	
RACE		EDUCATION	
OCCUPATION		MARRIAGE	
PLACE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF JUDGE		SIGNATURE OF JURY	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF DISTRICT ATTORNEY		SIGNATURE OF COUNTY CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF STATE ATTORNEY		SIGNATURE OF STATE CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF U.S. ATTORNEY		SIGNATURE OF U.S. CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF MARYLAND ATTORNEY		SIGNATURE OF MARYLAND CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF BALTIMORE ATTORNEY		SIGNATURE OF BALTIMORE CLERK	
DATE OF SIGNATURE		DATE OF SIGNATURE	
SIGNATURE OF MARYLAND DEPARTMENT OF HEALTH		SIGNATURE OF BALTIMORE DEPARTMENT OF HEALTH	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAR 6 1923

RECEIVED

3180

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eketon</i>		c. LENGTH OF STAY IN 1b <i>10 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARTHA</i> Middle <i>P.</i> Last <i>GRADEN</i>		4. DATE OF DEATH Month <i>3</i> Day <i>2</i> Year <i>1958</i>	
5. SEX <i>7</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-1884</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Chicago Ill.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Wheellock</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Palmer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>197-12-653B</i>	
17. INFORMANT <i>John Robert Graden</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE CORONARY OCCLUSION</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CORONARY ARTERIES THROMBOSIS</i> DUE TO (c) <i>CORONARY ARTERIES SCLEROSIS</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 week</i> <i>2-3 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X DIABETES MELLITUS, ACIDOSIS</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2.2.1958</i> to <i>3.2.1958</i> , that I last saw the deceased alive on <i>3.2.1958</i> , and that death occurred at <i>4:45 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>154 W. MAIN</i> DATE SIGNED <i>3.2.58</i>			
ACTUAL SIGNATURE <i>Peter Stavrakis</i>		M.D. <i>154 W. MAIN</i>	
PHYSICIAN'S NAME (Type) <i>PETER STAVRAKIS M.D.</i>		<i>ELKTON, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-4-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Eketon Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Eketon, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Walter duBois</i>		ADDRESS <i>Eketon, Md.</i>	
24a. REC'D BY REGISTRAR <i>154 W. MAIN</i>		24b. REGISTRAR'S SIGNATURE <i>154 W. MAIN</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

БУРКАУ V. 3

MAR 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03173

3181

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1 R.F.D-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Julius Green				4. DATE OF DEATH Month Day Year March 25 1958					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 4, 1893			
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina			
12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME Richard T. Green				14. MOTHER'S MAIDEN NAME Clara Rodgers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-22-9044		17. INFORMANT Address Irvin Green-953 Ellicott Dr. Balt. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion (c) Arteriosclerotic Heart Disease 7 min 4 years.								INTERVAL BETWEEN ONSET AND DEATH 7 min 4 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 22, 1958, to Mar 25, 1958, that I last saw the deceased alive on Mar 25, 1958, and that death occurred at 9:38 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cecil Han, Md. DATE SIGNED 3-28-58 ACTUAL SIGNATURE Wallace Oberhauser M.D. PHYSICIAN'S NAME (Type) Cecil Han									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/58		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edw. R. Bell				ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE 3/28/58		24b. REGISTRAR'S SIGNATURE Oberhauser	



**BUREAU V. S.**

MAR 31 1953

RECEIVED

3199

## CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Bainbridge, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Patricia</u> Last <u>Hayes</u>			4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1958</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1958</u>		9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bainbridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas T. Hayes</u>				14. MOTHER'S MAIDEN NAME <u>Laura Mae Sinclair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Thomas T. Hayes</u> Address <u>Bldg. 910 Apt. #3, Bainbridge Village, Bainbridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature, neonatal</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5 March</u> , 1958, to <u>6 March</u> , 1958, that I last saw the deceased alive on <u>6 March</u> , 1958, and that death occurred at <u>0435A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Allen P. Hartman</u> M.D. <u>U. S. Naval Hospital</u> <u>6 March 1958</u> PHYSICIAN'S NAME (Type) <u>ALLEN P. HARTMAN LT MC USNR</u> <u>Bainbridge, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7 March 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colora</u> <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson &amp; Son, Perryville, Md.</u> <u>I was stillborn et 2251263XVI</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Allen P. Hartman</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 7 1958

RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3200

## CERTIFICATE OF DEATH

03175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Chesapeake City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home</u>		d. STREET ADDRESS <u>Geo. &amp; Third Sts</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E.</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William P Howard</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth boulder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Elvira H. Davis</u>		Address <u>Chesapeake City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS</u> <u>450.0</u> DUE TO - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>19.55</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>MAY 5</u> , 19 <u>55</u> , to <u>MARCH 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 3</u> , 19 <u>58</u> , and that death occurred at <u>4:10</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3/2/58</u>			
ACTUAL SIGNATURE <u>Henry V. Davis MD</u> M.D.			
PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS</u>		<u>CHESAPEAKE CITY MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ELKTON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ELKTON, CEIL C., MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Frank</u>		ADDRESS <u>North East Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>March 7, 1938</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>	
16. SIGNATURE OF DECEASED <i>None</i>		17. SIGNATURE OF WITNESSES <i>None</i>		18. SIGNATURE OF REGISTRAR <i>None</i>	

BUREAU V. 8

MAR 7 1938

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3201

## CERTIFICATE OF DEATH

03176

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>				c. LENGTH OF STAY IN 1b <u>26 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u>			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Randolph Janney Sr.</u>				4. DATE OF DEATH Month Day Year <u>March 22 19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1866</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Train Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna R.R. Ret 26 yrs Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Janney of Eli</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Mahoney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>John Randolph Janney Jr. North East Rural Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis</u> DUE TO (c) <u>Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 1955</u> , to <u>March 22, 1958</u> , that I last saw the deceased alive on <u>March 21, 1958</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G H Richards Jr</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>P.O. Box 2, Cecil, Md 3/22/58</u>			
PHYSICIAN'S NAME (Type) <u>G H RICHARDS JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bay View Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Rural North East Cecil Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE	
5. PLACE OF BIRTH		6. DATE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF CLERK		18. SIGNATURE OF CHURCH		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF BURIAL PLACE	
21. SIGNATURE OF CEMETERY		22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWEE		24. SIGNATURE OF INTERVIEWER'S SUPERVISOR	
25. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		26. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		27. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		28. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
29. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		30. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		31. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		32. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
33. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		34. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		35. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		36. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
37. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		38. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		39. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		40. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
41. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		42. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		43. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		44. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
45. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		46. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		47. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		48. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
49. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		50. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		51. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		52. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
53. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		54. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		55. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		56. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
57. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		58. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		59. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		60. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
61. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		62. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		63. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		64. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
65. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		66. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		67. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		68. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
69. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		70. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		71. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		72. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
73. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		74. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		75. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		76. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
77. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		78. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		79. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		80. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
81. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		82. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		83. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		84. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
85. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		86. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		87. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		88. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
89. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		90. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		91. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		92. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
93. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		94. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		95. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		96. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	
97. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		98. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		99. SIGNATURE OF INTERVIEWEE'S SUPERVISOR		100. SIGNATURE OF INTERVIEWEE'S SUPERVISOR	

BURKAV Y. E.

MAR 26 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

03177

3202

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>				c. LENGTH OF STAY IN 1b <b>X Chesapeake City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>3</b> Day <b>8</b> Year <b>19 58</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-15-93</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>St. Augustine, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MOSE JONES</b>				14. MOTHER'S MAIDEN NAME <b>JANIE JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>219 01 4827</b>		17. INFORMANT Address <b>HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X Bronchopneumonia bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of prostate, widespread</b> DUE TO <b>metastasis to abdominal &amp; chest cavities &amp; lymph nodes</b> (c) <b>Arteriosclerosis, generalized, severe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 to 6 days</b> <b>Unk.</b> <b>Unk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-3-</b> , 19 <b>58</b> , to <b>3-8-</b> , 19 <b>58</b> , and that death occurred at <b>8:44 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Joseph Grasberger</b> M.D. <b>VA Hospital, Perry Point, Md.</b> <b>3-9-58</b>							
ACTUAL SIGNATURE <b>Joseph Grasberger</b> M.D. <b>VA Hospital, Perry Point, Md.</b> <b>3-9-58</b>							
PHYSICIAN'S NAME (Type) <b>JOSEPH GRASBERGER, M.D., Acting Director, Professional Services</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/12/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bohemia Manor</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Bell</b> ADDRESS <b>EDWARD BELL FUNERAL HOME, Wilmington, Del.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 3

MAR 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3203

## CERTIFICATE OF DEATH

Reg. Dist. No.

03178

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>	c. LENGTH OF STAY IN 1b <u>70 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Thomas Keetley</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>6</u> - Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Chester Co. Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Keetley</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Terry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Elizabeth Keetley Colora Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of stomach &amp; intestines</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Cecil</u> , 19 <u>58</u> , to <u>3-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-5</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G.H. Richards</u> M.D.		ADDRESS (Street, city or town, state) <u>Post Deposit Md.</u> DATE SIGNED <u>3-8-58</u>	
PHYSICIAN'S NAME (Type) <u>G.H. Richards M.D. Post Deposit Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cernon E. McMillen</u>		ADDRESS <u>Rising Sun Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 11 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	



BUREAU V. S.

MAR 11 1958

RECEIVED

3182

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>20 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.3.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Weldon</b> Last <b>Kent</b>				4. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-3-1923</b>		9. AGE (In years last birthday) <b>34</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Auto.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen Motors</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William W. Kent.</b>				14. MOTHER'S MAIDEN NAME <b>Alice Hurd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W. 2</b>		16. SOCIAL SECURITY NO. <b>221-12-8512</b>		17. INFORMANT <b>Mrs. William W. Kent, Elkton, R.D.3, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c) <b>420.1</b> DUE TO causing the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>0</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3-13-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton, Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>				ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>3-17-58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overhiser</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased William W. Kent		Sex Male		Age 30		Date of Death 10-3-1953	
Place of Birth Boston, Mass.		Usual Residence Boston, Mass.		Cause of Death Acute coronary thrombosis		Manner of Death Natural	
Signature of Physician [Signature]		Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]	
Hospital or Place of Death Union Hospital		City Boston		County Suffolk		State Mass.	

**RECEIVED**  
MAR 17 1958  
BUREAU V. 3

## 3204 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Michigan b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural				c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adrian 49X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1004 Treat Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Jackline Ann Lewis				4. DATE OF DEATH Month Day Year March 28 19 58			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1957	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Adrian, Michigan				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Dah Richard Lewis				14. MOTHER'S MAIDEN NAME Marilyn Herd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Marilyn Lewis 1004 Treat St., Adrian Michigan			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 482X Acute gastroenteritis - influenza DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 085.0 Measles INTERVAL BETWEEN ONSET AND DEATH 4 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from 28 March, 1958, to 28 March, 1958, that I last saw the deceased alive on 28 March, 1958, and that death occurred at 11 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Hubner M.D.				ADDRESS (Street, city or town, state) DATE SIGNED North East Md 29 March 1958			
PHYSICIAN'S NAME (Type) Klaus H. Hubner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3-29-58		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Adrian, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE MAR 31 '58	
				24b. REGISTRAR'S SIGNATURE W. J. Search			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL CERTIFICATION

VS AIS (4)  
15M 9/SS

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

MAR 31 1958

RECEIVED

3206

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>18yrs.6mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Roland Park, Baltimore</b> <b>3vol-4</b>			
f. STREET ADDRESS <b>4605 Wilmslow Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOEL</b>		First <b>W.</b>		Middle <b>MASSIE</b>		Last	
4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 58</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-4-1894</b>		9. AGE (In years last birthday) yrs. <b>64</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Practice</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Patrick C. Massie</b>			
14. MOTHER'S MAIDEN NAME <b>Elizabeth Kirkman</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>				17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>20 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 8, 19 39</b> , to <b>March 7, 19 58</b> , and that death occurred at <b>1:55 a.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Joseph Gruber</b> M.D. <b>V.A. Hospital, Perry Point, Md.</b> <b>3-7-58</b> PHYSICIAN'S NAME (Type) <b>J. C. GRASBERGER, M.D. Acting Director, Professional Services</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3-8-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son, Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
CERTIFICATE OF DEATH

ENDING

RECEIVED  
MAR 11 1958  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03183

3207

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b> <b>Cecil</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Norman H. McMullen</b>				4. DATE OF DEATH Month Day Year <b>March 24 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/5/79</b>	
9. AGE (In years lost birthday) <b>78</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hazlett McMullen</b>		14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Kathryn S. McMullen, Perryville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial</b> DUE TO (c) <b>Infarct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 1, 1954</b> , to <b>March 24, 1958</b> , that I last saw the deceased alive on <b>March 23, 1958</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. H. Richards, Jr.</b>				ADDRESS (Street, city or town, state) <b>Perryville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>G. H. Richards, Jr., M.D.</b>				DATE SIGNED <b>3/24/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/26/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Perryville Rural Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>Alfred</b>	
DATE <b>MAR 27 1958</b>				24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			



# CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Jackson, Mississippi	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
Never married						Mary Lee Ray		April 4, 1968		Memphis, Tennessee	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		CAUSE OF DEATH		MANNER OF DEATH	
Attorney		High School		Methodist		None		Heart Disease		Natural	
PREVIOUS ILLNESS		DATE OF PREVIOUS ILLNESS		PLACE OF PREVIOUS ILLNESS		NAME OF PHYSICIAN		DATE OF BURIAL		PLACE OF BURIAL	
None						Dr. J. H. Smith		April 6, 1968		Greenwood Cemetery, Memphis, Tennessee	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	

BUREAU V. S.

MAR 27 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03184

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

3208

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>8mos. 13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2638 St. Benedict Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHRISTIAN</b> Middle <b>D.</b> Last <b>MILLIGAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-25-1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>30</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Months <b>4</b> Days <b>30</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>FRED B. MILLIGAN</b>				14. MOTHER'S MAIDEN NAME <b>MARY BAKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW-II</b>				16. SOCIAL SECURITY NO. <b>265-07-4667</b>		17. INFORMANT <b>Hospital Records, VA Hosp., Perry Point, Maryland</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Edema pulmonary acute, due to remote trauma</b> DUE TO <b>191.6</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. <b>Surgical removal of the right shoulder girdle 3-28-58</b> DUE TO <b>Recurrent epidermoid carcinoma of the skin, right shoulder</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>unknown</b> INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hours</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 17, 1957</b> to <b>March 30, 1958</b> and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>3-31-58</b> ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D. PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b> Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre DeGrace, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. DeLoach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MADE IN U.S.A.  
FIVE MINUTE BOND

BUREAU V. S.

APR 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3183

CERTIFICATE OF DEATH

03185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 36 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Moore		4. DATE OF DEATH Month Day Year March 19 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1958
9. AGE (In years lost birthday) yrs. 36		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Lee Moore		14. MOTHER'S MAIDEN NAME Ann Umberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert Lee Moore		Address North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 774x Premature infant - 2 lbs 3 oz. DUE TO (b) Premature labor - cause undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 17 March, 1958, to 19 March, 1958, that I last saw the deceased alive on 19 March, 1958, and that death occurred at 7:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huchner		ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 19 March 1958	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/21/58	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East Cecil Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant		ADDRESS North East, Md.	
24a. REC'D BY REGISTRAR DATE 24 '58		24b. REGISTRAR'S SIGNATURE	

2065-222XVO

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910"]	
PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "March 24, 1958"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF NEXT OF KIN [Faint text, possibly "Jane Doe"]	

BUREAU V. S.

MAR 24 1958

RECEIVED



3209

## CERTIFICATE OF DEATH

03186

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Earleville		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Sarah First Jane Middle Moore Last		4. DATE OF DEATH March 4, 19 58 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Samuel Hurd	
14. MOTHER'S MAIDEN NAME Marth Bailey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT George W. Moore Earleville Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 25, 1958, to Mar 4, 1958 that I last saw the deceased alive on Mar 4, 1958, and that death occurred at 6:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Plushkin M.D.		ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 5 Mar 58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 7, 1958	22c. NAME OF CEMETERY OR CREMATORY Galena Cem.	22d. LOCATION (City, town, or county) (State) Galena Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Yellow		24a. REC'D BY REGISTRAR DATE MAR 10 '58	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03187

3184

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Hindman Last Piner		4. DATE OF DEATH Month March Day 12 Year 1958	
5. SEX F	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Hindman		14. MOTHER'S MAIDEN NAME Annie Congo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hattie Hindman		117 Milbourn St. Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO MASSIVE CEREBRAL HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL VASCULAR SCLEROSIS (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 1 day 2-3 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-11, 1958, to 3-12, 1958, that I last saw the deceased alive on 3-12, 1958, and that death occurred at 10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Peter Stavrakis M.D. 154 W. MAIN 3-14-58 PHYSICIAN'S NAME (Type) PETER STAVRAKIS M.D. ELKTON, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15-1958	
22c. NAME OF CEMETERY OR CREMATORY Providence Methodist		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Piper Funeral Home 1212 E. ELKTON, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

MAR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3185

## CERTIFICATE OF DEATH

03188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS 103 Locust Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Grace Wells Price				4. DATE OF DEATH March 25, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1891	
				9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Maryland	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank P. Price				14. MOTHER'S MAIDEN NAME Ella Cantwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-20-1252		17. INFORMANT Mrs. Grace Price Zogbaum	
						Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe upper respiratory virus infection 1 month ago 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 1 hour							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 18, 1958, to March 25, 1958, that I last saw the deceased alive on March 25, 1958, and that death occurred at 9:40a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. 233 E. Main Street March 25, 1958 PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Pippin Funeral Home 6674 Lee Elkton, Md.				24a. REC'D BY REGISTRAR DATE MAR 31 '58		24b. REGISTRAR'S SIGNATURE	





## CERTIFICATE OF DEATH

Reg. Dist. No.

3210

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b>				c. LENGTH OF STAY IN 1b <b>3 Weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Graybeal Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Herbert</b> Last <b>Rogers</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 24 1880</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Steamship Captain</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nova Scotia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Rogers</b>				14. MOTHER'S MAIDEN NAME <b>Sara Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Joseph Santiago</b>	
				<b>204 Ridge Ave.</b>		<b>Towson 4 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension and Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3-25-58</b> , 19 <b>58</b> , to <b>3-30-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-25-58</b> , 19 <b>58</b> , and that death occurred on <b>3-30-58</b> , 19 <b>58</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>3-31-58</b>							
ACTUAL SIGNATURE <b>R. C. Dodson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R. C. Dodson</b> M.D.				<b>Rising Sun, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 2 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>		22d. LOCATION (City, town, or county) (State) <b>Near Colora, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Syron</b>				ADDRESS <b>Rising Sun, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 2 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Earl Syron</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3186

## CERTIFICATE OF DEATH

03190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>BRUCE</u> Last <u>RONIG</u>				4. DATE OF DEATH Month <u>MAR.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 19, 1957</u>	
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELKTON, MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GEORGE W. RONIG</u>				14. MOTHER'S MAIDEN NAME <u>SARAH E. POTTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. GEORGE RONIG</u> Address <u>EARLVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>756.2</u> DUE TO <u>INTUSSUSCEPTION OF ILEUM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3174 ECKEL DIVERTICULUM</u> DUE TO (c) <u>GANGRENE OF ILEUM</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u> <u>LIFE</u> <u>12 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>3</u>				20g. (County) <u>3</u>		20h. (State) <u>3</u>	
21. I certify that I attended the deceased from <u>MARCH 8, 1958</u> to <u>MARCH 10, 1958</u> , that I last saw the deceased alive on <u>MARCH 10, 1958</u> , and that death occurred at <u>1:58 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY, MD</u>			
DATE SIGNED <u>3/10/58</u>							
PHYSICIAN'S NAME (Type) <u>HENRY V. PAUS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WHITE CHAPEL GARDENS, FEASTERVILLE, PA.</u>		22d. LOCATION (City, town, or county) (State) <u>PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellos, Millington, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

2065376XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		JAN 24 1928	
6. PLACE OF BIRTH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
MEMPHIS, TENN.		MEMBER OF CONGRESS		HEART DISEASE		NATURAL		MEMPHIS, TENN.	
11. DATE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
APR 4 1968		4:00 PM		[Signature]		[Signature]		[Signatures]	
16. COUNTY		17. CITY		18. STATE		19. ZIP CODE		20. FEDERAL BUREAU OF INVESTIGATION	
SHELBY		MEMPHIS		TENN.		38102		[Stamp]	
21. NAME OF FUNERAL HOME		22. NAME OF CEMETERY		23. NAME OF CLERGYMAN		24. NAME OF MINISTER		25. NAME OF CHURCH	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU Y. B.

MR 14 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3187

## CERTIFICATE OF DEATH

03191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Haven Nursing Home</u>				d. STREET ADDRESS <u>Moffitt St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Russell</u>				4. DATE OF DEATH Month Day Year <u>March 18 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 22, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>----- Windell</u>				14. MOTHER'S MAIDEN NAME <u>No Info.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. John Zahn</u>		Address <u>Nr. Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Herpes zoster</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 17</u> , 1956, to <u>March 18</u> , 1958, that I last saw the deceased alive on <u>March 17</u> , 1958, and that death occurred at <u>9:15a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>233 E. Main Street</u> <u>3/19/58</u> ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. <u>Elkton, Maryland</u> PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 22, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 22 FilmG227 4-15-58 et  
3211  
CERTIFICATE OF DEATH

03192  
96

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Pike	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bushkill 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ELLEN Middle E. Last SANDERSON		4. DATE OF DEATH Month March Day 9 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-74
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Phillipsburg, N. J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Sanderson		14. MOTHER'S MAIDEN NAME Lydia Jane Lynd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, massive, gastro-intestinal DUE TO (b) Cirrhosis of the liver DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, severe - unknown		INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks unknown unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 19 58, to March 9, 19 58, and that death occurred at 8:55 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE S. P. LACERVA M.D. V.A. Hospital, Perry Point, Md. 3-10-58 PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/11/58	
22c. NAME OF CEMETERY OR CREMATORY unknown Fairmount		22d. LOCATION (City, town, or county) (State) Fairmount, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAR 17 '58	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. E.

MAR 17 1958

RECEIVED

## CERTIFICATE OF DEATH

Item 21 Film 227 4-2-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>3212</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Vincenzo</b> <b>Sellare</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1893</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>USA Italy</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Track Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA Italy</b>	
13. FATHER'S NAME <b>Joseph Sellare</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-07-5380</b>	
17. INFORMANT <b>Mrs. Antoinette V. Sellare, Perryville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 1957</b> to <b>March 26, 1958</b> , that I last saw the deceased alive on <b>March 26, 1958</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Port Deposit, Md</b> DATE SIGNED <b>3/27/58</b> ACTUAL SIGNATURE <b>Clarence J. Benson</b> M.D. <b>Port Deposit, Md</b> PHYSICIAN'S NAME (Type) <b>Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Erin Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Havre de Grace, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Vera Patterson &amp; Son, Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		UNITED STATES				APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES			
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		MEDICAL EXAMINER		PATHOLOGIST		FORENSIC PATHOLOGIST		CORONER		JURY		JUDGE		CLERK	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		HEART DISEASE		SUICIDE		STATE OF TENNESSEE		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY		DR. JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES																					
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF PATHOLOGIST		SIGNATURE OF FORENSIC PATHOLOGIST		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF PATHOLOGIST		SIGNATURE OF FORENSIC PATHOLOGIST	

BUREAU V. 2

MAR 31 1968

RECEIVED

Item 18 Film 227 4-8-58 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
3. NAME OF DECEASED (Type or print) First Middle Last Perry Henry Sewell		4. DATE OF DEATH Month Day Year March 23 1958		5. SEX Male		6. COLOR OR RACE C	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1884		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Harriett Sewell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-20-8916		17. INFORMANT Edna G. Sewell-Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Interstitial Nephritis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia Poison DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 Years 2 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 12, 1957, to March 23, 1958, that I last saw the deceased alive on March 18, 1958, and that death occurred at 5:13 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James L. Johnson M.D. Elkton, Maryland 3/24/58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James L. Johnson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/58		22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.		22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. R. Bell				ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DATE 3/24/58	
				24b. REGISTRAR'S SIGNATURE Overhanch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 65	
4. OCCUPATION Retired		5. MARITAL STATUS Married		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH Jan 28 1939		8. TIME OF DEATH 10:15 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. H. Smith	
13. SIGNATURE OF REGISTRAR J. H. Smith		14. SIGNATURE OF WITNESSES J. H. Smith		15. SIGNATURE OF DECEASED J. H. Smith	
16. SIGNATURE OF DECEASED J. H. Smith		17. SIGNATURE OF DECEASED J. H. Smith		18. SIGNATURE OF DECEASED J. H. Smith	
19. SIGNATURE OF DECEASED J. H. Smith		20. SIGNATURE OF DECEASED J. H. Smith		21. SIGNATURE OF DECEASED J. H. Smith	
22. SIGNATURE OF DECEASED J. H. Smith		23. SIGNATURE OF DECEASED J. H. Smith		24. SIGNATURE OF DECEASED J. H. Smith	
25. SIGNATURE OF DECEASED J. H. Smith		26. SIGNATURE OF DECEASED J. H. Smith		27. SIGNATURE OF DECEASED J. H. Smith	
28. SIGNATURE OF DECEASED J. H. Smith		29. SIGNATURE OF DECEASED J. H. Smith		30. SIGNATURE OF DECEASED J. H. Smith	
31. SIGNATURE OF DECEASED J. H. Smith		32. SIGNATURE OF DECEASED J. H. Smith		33. SIGNATURE OF DECEASED J. H. Smith	
34. SIGNATURE OF DECEASED J. H. Smith		35. SIGNATURE OF DECEASED J. H. Smith		36. SIGNATURE OF DECEASED J. H. Smith	
37. SIGNATURE OF DECEASED J. H. Smith		38. SIGNATURE OF DECEASED J. H. Smith		39. SIGNATURE OF DECEASED J. H. Smith	
40. SIGNATURE OF DECEASED J. H. Smith		41. SIGNATURE OF DECEASED J. H. Smith		42. SIGNATURE OF DECEASED J. H. Smith	
43. SIGNATURE OF DECEASED J. H. Smith		44. SIGNATURE OF DECEASED J. H. Smith		45. SIGNATURE OF DECEASED J. H. Smith	
46. SIGNATURE OF DECEASED J. H. Smith		47. SIGNATURE OF DECEASED J. H. Smith		48. SIGNATURE OF DECEASED J. H. Smith	
49. SIGNATURE OF DECEASED J. H. Smith		50. SIGNATURE OF DECEASED J. H. Smith		51. SIGNATURE OF DECEASED J. H. Smith	
52. SIGNATURE OF DECEASED J. H. Smith		53. SIGNATURE OF DECEASED J. H. Smith		54. SIGNATURE OF DECEASED J. H. Smith	
55. SIGNATURE OF DECEASED J. H. Smith		56. SIGNATURE OF DECEASED J. H. Smith		57. SIGNATURE OF DECEASED J. H. Smith	
58. SIGNATURE OF DECEASED J. H. Smith		59. SIGNATURE OF DECEASED J. H. Smith		60. SIGNATURE OF DECEASED J. H. Smith	
61. SIGNATURE OF DECEASED J. H. Smith		62. SIGNATURE OF DECEASED J. H. Smith		63. SIGNATURE OF DECEASED J. H. Smith	
64. SIGNATURE OF DECEASED J. H. Smith		65. SIGNATURE OF DECEASED J. H. Smith		66. SIGNATURE OF DECEASED J. H. Smith	
67. SIGNATURE OF DECEASED J. H. Smith		68. SIGNATURE OF DECEASED J. H. Smith		69. SIGNATURE OF DECEASED J. H. Smith	
70. SIGNATURE OF DECEASED J. H. Smith		71. SIGNATURE OF DECEASED J. H. Smith		72. SIGNATURE OF DECEASED J. H. Smith	
73. SIGNATURE OF DECEASED J. H. Smith		74. SIGNATURE OF DECEASED J. H. Smith		75. SIGNATURE OF DECEASED J. H. Smith	
76. SIGNATURE OF DECEASED J. H. Smith		77. SIGNATURE OF DECEASED J. H. Smith		78. SIGNATURE OF DECEASED J. H. Smith	
79. SIGNATURE OF DECEASED J. H. Smith		80. SIGNATURE OF DECEASED J. H. Smith		81. SIGNATURE OF DECEASED J. H. Smith	
82. SIGNATURE OF DECEASED J. H. Smith		83. SIGNATURE OF DECEASED J. H. Smith		84. SIGNATURE OF DECEASED J. H. Smith	
85. SIGNATURE OF DECEASED J. H. Smith		86. SIGNATURE OF DECEASED J. H. Smith		87. SIGNATURE OF DECEASED J. H. Smith	
88. SIGNATURE OF DECEASED J. H. Smith		89. SIGNATURE OF DECEASED J. H. Smith		90. SIGNATURE OF DECEASED J. H. Smith	
91. SIGNATURE OF DECEASED J. H. Smith		92. SIGNATURE OF DECEASED J. H. Smith		93. SIGNATURE OF DECEASED J. H. Smith	
94. SIGNATURE OF DECEASED J. H. Smith		95. SIGNATURE OF DECEASED J. H. Smith		96. SIGNATURE OF DECEASED J. H. Smith	
97. SIGNATURE OF DECEASED J. H. Smith		98. SIGNATURE OF DECEASED J. H. Smith		99. SIGNATURE OF DECEASED J. H. Smith	
100. SIGNATURE OF DECEASED J. H. Smith		101. SIGNATURE OF DECEASED J. H. Smith		102. SIGNATURE OF DECEASED J. H. Smith	

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MAR 28 1939  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 03195

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Conowingo</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rural-Conowingo</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Virginia Elizabeth Taylor</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Strawbridge Gerry</u>		14. MOTHER'S MAIDEN NAME <u>Elisabeth Virginia Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-01-66058</u>	
17. INFORMANT <u>Horace W. Taylor</u>		Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Tongue</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>141.9</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> 19 <u>57</u> , to <u>March</u> 19 <u>58</u> , that I last saw the deceased alive on <u>3-1</u> 19 <u>58</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/4/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-8-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Coloma, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon E. McMullan</u>		ADDRESS <u>Rising Sun, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>MAR 7 '58</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3215 CERTIFICATE OF DEATH

03196

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Chester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rising Sun				c. LENGTH OF STAY IN 1b 6 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Chathan, Pa. 75 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graybeal Conv. Home				d. STREET ADDRESS Route 41			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Gurney P. Tingley				4. DATE OF DEATH Month Day Year March 12, 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1877		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Agricultural farm		11. BIRTHPLACE (State or foreign country) New London, Ches. Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Lamont Tingley				14. MOTHER'S MAIDEN NAME Emily Worrall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Worrall Tingley, Chatham, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Peptic Ulcer and Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-12</u> , 19 <u>58</u> , to <u>3-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-12-58</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D. <u>Rising Sun, Md.</u> <u>3-12-58</u> PHYSICIAN'S NAME (Type) <u>R. C. Dodson, M.D.</u> <u>Rising Sun, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Faggs Manor Cemetery		22d. LOCATION (City, town, or county) (State) Chester County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Carl Tyson Rising Sun, Md.				24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE W. B. Smith	

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4. The following information is provided for the year ended 31 December 2014:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3216

CERTIFICATE OF DEATH

Reg. Dist. No.

03197

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>			
c. LENGTH OF STAY IN 1b <b>12yrs/4mo9days</b>				d. STREET ADDRESS <b>3 E. 3rd St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLARD</b>		First <b>B.</b> Middle <b>TOMLINSON</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Wilmington, Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Tomlinson</b>				14. MOTHER'S MAIDEN NAME <b>Anna Murray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho - pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>491X</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chronic brain syndrome associated with CNS syphilis.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>11-6</b> to <b>3-15</b> , 19 <b>58</b> , and that death occurred at <b>3:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA</b> DATE SIGNED <b>3-15-58</b>							
ACTUAL SIGNATURE <b>E. S. ELLS, M.D.</b>				M.D. <b>3-15-58</b>			
PHYSICIAN'S NAME (Type) <b>Acting Director Professional Services, VAH, Perry Point, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert J. McCarty</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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CERTIFICATE OF DEATH

BUREAU V. S.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03198

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First Preston Middle Wesley Last		4. DATE OF DEATH Month 3 Day 2 Year 19 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1942
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Evan Wesley		14. MOTHER'S MAIDEN NAME Pearl Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Address Pearl Wesley, Cecilton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot by another boy	
20c. TIME OF INJURY Month, Day, Year Hour 11:10 p. m. 3/1 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Building		20f. (City or town) Cecil (County) Maryland (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/58	
22c. NAME OF CEMETERY OR CREMATORY Griffin Cemetery		22d. LOCATION (City, town, or county) Cedar Hill, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward R. Ball 909 Poplar St.		24a. REC'D BY REGISTRAR DATE MAR 5 '58	
		24b. REGISTRAR'S SIGNATURE	



NEWLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

8501

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville R.D.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
c. LENGTH OF STAY IN 1b <b>20 yrs</b>		d. STREET ADDRESS <b>Front and Elm</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Charlestown Gravel Bank Bank</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grady</b> Middle <b>Williams</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>3</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>M</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attend. V.A. Hosp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>V.A. Hospital</b>	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Mac Williams</b>	
14. MOTHER'S MAIDEN NAME <b>Sara Rebecca All</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>217-18-6440</b>		17. INFORMANT <b>Mrs. Bessie Williams, Perryville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Penetrating bullet wound in left side of forehead</b> DUE TO (b) <b>with loss of brain tissue</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self with 32 caliber revolver</b>	
20c. TIME OF INJURY Month, Day, Year <b>3 15 1958</b> Hour <b>2</b> P. <b>7</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Gravel Bank</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Perryville R.D. Cecil Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3-17-58</b>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-20-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Principio Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Principio Furnace, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Lee A. Patterson</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARMY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Residence		Place of Death	
WILLIAM, GEORGE		Baltimore, Md.		Baltimore, Md.	
Age		Sex		Race	
30 yrs		Male		White	
Date of Death		Cause of Death		Manner of Death	
1-28-1938		Shot with .38 caliber revolver		Suicide	
Place of Burial		Name of Burial Place		Name of Minister	
Greenwood		Greenwood		Rev. J. H. Jones	
Signature of Medical Examiner		Signature of Coroner		Signature of Physician	
[Signature]		[Signature]		[Signature]	

Penetrating bullet wound in left side of forehead  
with loss of brain tissue

Shot with .38 caliber revolver

**BUREAU V. S.**  
**RECEIVED**  
MAR 19 1938

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3189

## CERTIFICATE OF DEATH

Reg. Dist. No. 03200

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELRTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>Wilmore</u> Last <u>Wilmore</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>LIZZIE BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>HENRIETTA WILMER.</u> Address <u>CECILTON, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u> <u>5 yrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month _____	Day _____	Year _____	20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/19</u> , 19 <u>58</u> , to <u>3/20</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>19 March</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huchner</u> M.D.				ADDRESS (Street, city or town, state) <u>North East Rd</u>		DATE SIGNED <u>21 March '58</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CECILTON COL. CEM.</u>	22d. LOCATION (City, town, or county) <u>CECILTON</u>	(State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hellous, Beltington, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>1958</u>		





3218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>ELLA</i> Middle Last <i>WILSON</i>		4. DATE OF DEATH Month <i>March</i> Day <i>29</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 10 1879</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>usa.</i>	
13. FATHER'S NAME <i>William Harvie</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>Arnetta Brown</i>		Address <i>616 Maple Place Withers, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>year</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 4</i> , 19 <i>58</i> , to <i>Mar 29</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Mar 29</i> , 19 <i>58</i> , and that death occurred at <i>1:10</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oberheim</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecilton, md</i> DATE SIGNED <i>1 Apr 58</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>4/3/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cecilton Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Cecilton md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Bellows</i> ADDRESS <i>Wilmington md.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 7 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W.D. Seaborn</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 7 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03202

Reg. Dist. No. 96

3219

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>5111 Sunset Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Milton (NMI) WINNER</u>		4. DATE OF DEATH Month Day Year <u>March 29, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-23-14</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Not ascertainable</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Winner</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Mazer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Not ascertainable</u>	
17. INFORMANT <u>VAH, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. DODSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-30-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eaten Place</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BADGE NO. 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. SMITH		45		M		W		APR 1 1958		AT HOME	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 MAIN ST. BALTIMORE, MD.		Carpenter		High School		Married		Heart Disease		Natural	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		HABITS	
None		None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		WITNESSES		REMARKS	
J. M. SMITH		APR 1 1958		10:00 AM		AT HOME		J. M. SMITH, J. M. SMITH		None	



RECEIVED  
 APR 1 1958  
 BUREAU V. 3

RECEIVED

APR 1 1958

BUREAU V. 3